



## Texas Department of Criminal Justice

**Brad Livingston**  
Executive Director

**Date Faxed:** \_\_\_\_\_

### **THE STATE OFFICE OF RISK MANAGEMENT**

**Workers' Compensation Division**

**Fax #: (512) 370-9025**

**Human Resources Headquarters**

**Fax #: (936) 437-4140**

**RE: NAME:** \_\_\_\_\_

**SSN:** \_\_\_\_\_

**DATE OF INJURY OR ILLNESS:** \_\_\_\_\_

The original report for the above injury or illness is attached. Your office was initially notified by the Agency's Workers' Compensation department via entry into the SORM on-line system.

Sincerely,

\_\_\_\_\_  
**Signature**

**Human Resources Representative:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Unit/Department Name:** \_\_\_\_\_

**Unit/Department Address:** \_\_\_\_\_

**Attachments:**

**cc: Unit or Department Medical File**